

DENTAL PLAN DIRECT PAYMENT AUTHORIZATION

STATE OF CALIFORNIA

STD 696 (REV 6/2001)

INSTRUCTIONS: Review General Instructions on the reverse of this form. Then, complete the following parts of this form for employees enrolled in a dental plan who are going on non-pay status (i.e., the employee will **not** receive a warrant from the State Controller's Office).

1. Parts A and B and Part D, Item 16—Employees who do not wish to continue dental coverage.
2. Parts A, C and D—Employees who wish to continue dental coverage.

PLEASE TYPE OR PRINT USING BALL POINT PEN

PART A EMPLOYEE INFORMATION

1. SOCIAL SECURITY NUMBER (SEE REVERSE FOR DISCLOSURE STATEMENT)	2. NAME (FIRST) (MIDDLE) (LAST)
3. HOME PHONE NUMBER	4. MAILING ADDRESS (STREET) (CITY) (STATE) (ZIP CODE)
5. DENTAL CARRIER	6. CARRIER ADDRESS

PART B COVERAGE NOT RETAINED

7. I do not wish to continue my dental plan coverage while off pay status. I understand my coverage will terminate at the end of the first full month I am off pay status and will not resume until the beginning of the second month after I return to pay status.

Employee Signature _____ Date _____

PART C PREMIUM PAYMENT AGREEMENT

8. Complete the premium calculations below. Direct payment may not exceed one year for any carrier. Payment must be for a three-month period or the length of the absence, whichever is less. The initial payment is due to the carrier on the first day of the month following the first full month the employee is off pay status. Installment and/or final payment(s) (if applicable) will then be due to the carrier on the first of each succeeding three-month period.

8.A. INITIAL PAYMENT (Submit directly to carrier with this form): \$ _____ Due Date: _____ .

8.B. INSTALLMENT PAYMENT(S) (IF APPLICABLE): \$ _____ Due Date(s): _____ .

8.C. FINAL PAYMENT (IF APPLICABLE): \$ _____ Due Date: _____ .

9. I agree to pay all premiums directly to the dental plan carrier listed above by the specified due date(s) to cover the cost of enrollment as it is now or as it may be in the future. I understand that failure to pay premiums will result in suspension of my coverage. I also understand that the carrier will not bill me for any premium and no employer contribution will be made during the direct payment period.

Employee Signature _____ Date _____

PART D AGENCY INFORMATION (To be completed by the Personnel Office)

10. NAME OF EMPLOYING AGENCY	12. EMPLOYEE POSITION INFORMATION			
11. ADDRESS OF EMPLOYING AGENCY	AGENCY	UNIT	DESIGNATION	BARG. UNIT
13. REASON FOR DIRECT PAYMENT (SEE REVERSE FOR LIST OF SITUATIONS)				
14. DATES OF ABSENCE MONTH DAY YEAR MONTH DAY YEAR FROM: TO:			15. PAY PERIOD OF LAST PREMIUM DEDUCTION MONTH YEAR	
16. AUTHORIZED AGENCY SIGNATURE 			17. TELEPHONE NUMBER	18. DATE

1—CARRIER COPY

2—EMPLOYEE COPY

3—DEPARTMENT COPY

DISCLOSURE OF SOCIAL SECURITY NUMBERS

Section 7(b) of the Privacy Act of 1974 (Public Law 93-579) requires that any governmental agency which requests an individual to disclose his/her social security account number shall inform that individual whether that disclosure is mandatory or voluntary, by which statutory or other authority such number is solicited, and what uses will be made of it.

The dental insurance carriers under contract with the State of California request each enrollee's social security account number on a voluntary basis. However, it should be noted that due to the use of social security account numbers by the dental carriers for identification purposes, the dental insurance carriers may be unable to verify dental plan enrollment and ensure continuation of dental coverage without disclosure of the social security number.

Each dental insurance carrier may use the social security account number for enrollee verification and for eligibility processing only.

DENTAL PLAN DIRECT PAYMENT GENERAL INSTRUCTIONS

I. TYPES OF SITUATIONS NECESSITATING DIRECT PAYMENT BY THE EMPLOYEE TO CONTINUE COVERAGE INCLUDE THE FOLLOWING:

1. Leave of absence other than NDI, IDL, or Workers' Compensation with Supplementation.
2. Appeal for dismissal. (COBRA provisions apply; direct payment provisions are not applicable.)
3. Suspension of one or more complete pay periods.
4. Permanent Intermittent, off pay status. (COBRA provisions apply; direct payment provisions are not applicable.)
5. Applied for Disability Retirement, off pay status.*
6. Awaiting IDL determination when all sick leave and vacation credits have been exhausted.*

* **NOTE:** Employees enrolled in a dental plan who are on non-pay status while awaiting a disability determination must direct pay if they wish to have their coverage continued. At such time as the State Controller's Office (SCO) issues warrants which include dental deductions for the months when the employee has made direct payment, the employee may apply directly to the carrier for a refund.

II. EMPLOYEES WHO DO NOT ELECT TO RETAIN DENTAL COVERAGE WHILE ON NON-PAY STATUS ARE SUBJECT TO THE FOLLOWING TERMS:

1. Coverage will automatically resume effective the first day of the second month following the employee's return to pay status.
2. Deductibles accrued prior to the non-payment period **will not** be carried over.
3. Portions of qualifying time accrued for required waiting periods prior to the non-payment period **will not** be carried over.

III. EMPLOYEES WHO ELECT TO RETAIN DENTAL COVERAGE WHILE ON NON-PAY STATUS ARE SUBJECT TO THE FOLLOWING TERMS:

1. It is the employee's responsibility to provide the carrier with a copy of the completed Direct Payment Authorization Form (STD. 696) and all payments by the established due date(s). Do not send this Authorization to the SCO or to the Department of Personnel Administration.
2. If the employee wishes to add or delete a spouse or dependent(s) he/she must notify the departmental Health Benefits Officer, complete a new State Dental Plan Enrollment Authorization (STD. 692) and mail a completed copy directly to the carrier.
3. In the event the employee returns to pay status prior to completion of the period for which he/she has already made direct payment, the employee must contact the carrier directly to request a premium refund for any full, unused months of coverage.
4. Employees in Bargaining Units 5 and 6 must make all arrangements for direct payment through their exclusive representative.

IV. THE DEPARTMENT'S ROLE IN THE DIRECT PAYMENT PROCESS INCLUDES THE FOLLOWING:

1. Ensuring that this form is completed for all employees who are enrolled in a dental plan and on non-pay status for one or more complete pay periods.
2. Providing the employee with both the carrier and employee copies of the completed Direct Payment Authorization Form (STD. 696) and placing the departmental copy in the employee's personnel file.
3. Upon request of the employee, assisting in the addition or deletion of an eligible spouse or dependent(s) by completing a State Dental Plan Enrollment Authorization (STD. 692) and routing the original to the Controller's Office for processing.
4. Referring all Bargaining Unit 5 and 6 employees who wish to make direct payment to their exclusive representative.

V. EXAMPLES OF DIRECT PAYMENT CALCULATIONS:

1. An employee and spouse are enrolled in the ABC dental plan. The employee goes on a 6-month educational leave beginning October 1, 1997, and elects to retain dental coverage. (Assuming employee + 1 rate of \$56.21.)
INITIAL PAYMENT: **\$168.63**. DUE DATE: **Nov. 1, 1997**.
INSTALLMENT PAYMENT(S): **\$—0—**. DUE DATE(S): **None**.
FINAL PAYMENT: **\$168.63**. DUE DATE: **Feb. 1, 1998**.
2. An employee, her spouse and child are enrolled in the ABC dental plan. On July 10, 1997, the employee has a baby and begins a one-year maternity leave. She elects to retain her dental coverage, goes on NDI until August 22, 1997 and then non-pay status for the duration of the leave ending July 9, 1998. (Assuming employee + 2 rate of \$82.09.)
INITIAL PAYMENT: **\$246.27**. DUE DATE: **Oct. 1, 1997**.
INSTALLMENT PAYMENT(S): **\$246.27**. DUE DATE(S): **Jan. 1, 1998 and April 1, 1998**.
FINAL PAYMENT: **\$82.09**. DUE DATE: **July 1, 1998**.